EXHIBIT E

CSX TRANSPORTATION

FORM PI-1A ARM REV 6/99

EMPLOYEE'S INCIDENT REPORT

INSTRUCTIONS FOR FORM PI-1A

1. This report will be completed by the employee as soon as possible after an accident/incident. If the employee is unable to complete this form, it may be typed or written by another employee; the employee must initial each answer entered in this manner.
2. Completed Form PI-1A RPM will be furnished to the employee's supervisor who, after review of the report and seeing that it is complete and signed, will fax and then mail the original to the reporting office in Jacksonville.
3. Supervisor will furnish the claims representative, in whose area of responsibility the accident/incident occurred, a copy of this report.

01 INCIDENT NUMBER	02 EMPLOYEE NAME: PAUL T. PAPADAKIS	03 ID NUMBER: 788224	04 SOCIAL SECURITY NO.: 023384947
05 ADDRESS: 54 CARROLL LANE	FEEDING HILLS (City)	MA. (State)	01030 (Zip Code)
(413) 786158 (Phone No.)			
06 DATE OF BIRTH: 2-4-48	07 AGE: 53	08 OCCUPATION: T&R FOREMAN	09 DEPARTMENT: MW
10 SUPERVISION: R. ROSS			
11 DATE HIRED: 10-2-69	12 NUMBER CONSECUTIVE DAYS WORKED: 3	12a NUMBER OF HOURS OFF PRIOR TO TOUR OF DUTY: 15:2	
13 INCIDENT LOCATION: WEST WARREN	14 INCIDENT CITY: WEST WARREN	15 INCIDENT COUNTY: WORCESTER	16 INCIDENT STATE: MA.
17 REPORT (No. Nearest Tenth): 14.0	18 DIVISION: ALBANY SERVICE UNIT	19 INCIDENT DATE: Mo. 6 Day 13 Yr. 01	20 INCIDENT TIME: 5:00 ☐ AM ☒ PM
21 VISIBILITY: ☐ Dawn ☒ Daylight ☐ Dusk ☐ Dark			
22 WEATHER: ☒ Clear ☐ Rain ☐ Sleet ☐ Fog ☐ Snow	23 NATURE OF COMPLAINT: LOWER BACK		
24 WAS MEDICAL ATTENTION PROVIDED? If Yes, Name and Address of Physician: INTERNAL MEDICINE 377 WALNUT ST. EXT. PO BOX 788 BRAWM, MA. 01001			
25 OTHER MEDICAL FACILITY AND TREATMENT RECEIVED: BAYLEY HOSPITAL FOR X-RAYS	WAS PRESCRIPTION MEDICATION INCLUDED IN TREATMENT? ☒ YES ☐ NO		
26 DESCRIBE THE INCIDENT: I HAD JUST COMPLETED AN INSPECTION FORM MP127-74. WHEN I WAS LIFTING LEFT FRONT HI-RAIL WHEEL WITH BAR, THE GEAR ASSEMBLY BROKE TO RAISE WHEEL I HAD TO USE A LINING BAR AS A LEVER, THEN BLOCK WHEEL WITH 4" WOOD BLOCK AT SAME TIME, WHEN I RAISED DOWN W/BLOCK I FELT SOMETHING SNAP IN MY LOWER BACK			
27 IS THIS A RECURRENCE? ☐ Yes ☒ No			
28 WILL INCIDENT RESULT IN LOST WORKDAYS? ☐ Yes ☐ No If Yes, How Many?	29 WAS ANYONE AT FAULT? ☐ Yes ☒ No If Yes, Who and to What Extent?		
30 DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT? ☒ Yes ☐ No If Yes, Describe and Identify Defect: HY-RAIL MECHANISM			

ADDITIONAL SPACE FOR REPORT INFORMATION

DID EMPLOYEE HAVE A SAFE PLACE IN WHICH TO WORK?
31 ☐ Yes ☐ No If No, Explain Below

WAS THE WORKPLACE ADEQUATELY LIGHTED?
32 ☐ Yes ☐ No If No, Describe Conditions

WAS THE EMPLOYEE FURNISHED OR GIVEN THE EQUIPMENT NECESSARY (GLOVES, GOGGLES OR PROTECTION)?
33 ☐ Yes ☐ No

IF ON-TRACK EQUIPMENT WAS INVOLVED, GIVE INITIALS AND NOS.
34 TC 500285

LOCATION WHERE EMPLOYEE NORMALLY REPORTS.
NAME OF FACILITY West Springfield Yd.
35 STREET 101 Western Ave. CITY W. Springfield STATE MA. ZIP 01089

NAMES AND ADDRESSES OF WITNESSES TO THE INCIDENT
36

EMPLOYEE SIGNATURE
37 Paul T. Papa Jr.

WITNESS TO EMPLOYEE SIGNATURE
38

DATE
39 6/15/01

NAME OF SUPERVISOR NOTIFIED
40

MEDICAL INFORMATION RELEASE

I hereby authorize the release of all medical information reports and other medical data by any doctor, hospital, examiner or other health care provider relative to the injury(ies) sustained in this accident to the Chief Medical Officer and any other appropriate officer or representative of CSX TRANSPORTATION. A photocopy of this authorization is as valid as the original.

UNITED HEALTHCARE # 025000
SPECIFY TYPE OF INSURANCE COVERAGE (IDENTIFIED ON YOUR INSURANCE CARD)

Paul T. Papa Jr. 6/15/01
SIGNATURE OF EMPLOYEE DATE

IF YOU "DO NOT" WISH CSXT TO PAY THE TOTAL AMOUNT OF ANY MEDICAL BILLS RELATED TO THIS INJURY, PLEASE "CAREFULLY" READ THE FOLLOWING PAGE.